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APPENDIX 4

# Washington's Outpatient Services Extended Rate Study

*Developed for the*

**Washington Division of Alcohol and Substance Abuse**

**November 2006**

*Prepared by*

**James E. Sorensen, Ph.D., CPA**

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## Table of Contents

## Executive Summary

This study is the extended version of an earlier study done by the Division of Alcohol and Substance Abuse in July, 2006, at the request of the counties related to concerns of low reimbursement rates for outpatient treatment services. In October 2006, the Association of County Human Services (ACHS), an affiliate organization of the Washington State Association of Counties (WSAC), and the Washington Department of Social and Health Services Division of Alcohol and Substance Abuse (DASA) requested assistance from James E. Sorensen, Ph.D., CPA to help determine an appropriate reimbursement rate structure for DASA outpatient treatment services.

The extended study surveyed and acquired data for the study from 43 agencies across the State. Out of the total independent audits submitted only the data for 35 agencies were considered valid for the study purposes. Considering the rigorous requirements of the rate study, about 70 agencies statewide could provide the type of audits required for this type of study. Taking these requirements into account the study has about 50% statewide participation of its available providers with appropriate audits.

Under the direction of the Outpatient Rate Study Advisory Committee, Dr. Sorensen examined the data from several perspectives to establish actual costs versus rate reimbursements from DASA. During the initial visit of the study completed in July of 2006, the Advisory Committee as well as participating providers suggested the outpatient rate study would be enhanced if the results could be classified by factors believed to influence the cost structures of providers. These factors included:

- Urban or rural delivery site
- Large or small sized delivery organization
- Geographic location in either the eastern or western part of the State
- Type of population treated: adult or youth.

The independent audit reports of outpatient providers along with defined units of services and the State designated level of service were needed to advance the study of outpatient rates. Armed with the functional costs of the services, the costs of management and general administration and the annual units of service provided by service a cost-finding process was completed to determine the various outpatient rates for five services. The services included:

- Assessment
- Case Management
- Group Therapy
- Individual Therapy
- Opiate Substitution Treatment

In this 2006 extended study of the cost rates of the Washington Division of Alcohol and Substance (DASA) Outpatient Services***, the actual average cost of the services provided***

***exceeded the FY2005 DASA reimbursement rates by 47%*** for ninety-seven percent of the responding providers (n=35). Stated in other words, across all services providers and all services, providers were receiving reimbursement of 53% of costs (total costs of 100% less the deficiency of 47%) when using DASA reimbursement rates.

The 35 participants exhibited the following characteristics:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Urban | 71% | Larger | 74% | East | 31% | Adult | 83% |
| Rural | 29% | Smaller | 26% | West | 69% | Youth | 17% |
| Total | 100% | | 100% | | 100% | | 100% |

The sample was more heavily weighted toward urban, larger organizations located in the western part of the State and providing adult services. The actual profile classification of participating providers is presented in Table 1 and reveals a rich cross-section of providers in the sample. The smaller number of usable respondents places some limits on the ability to cross-classify the rates by the characteristics identified above.

In a phone survey conducted with the participants in the study, all (with the exception of one small provider) reported their private pay units of service in TARGET. While some private pay clients units of service may be unreported, the amounts are deemed to be immaterial and the use of TARGET data for determining units of service for this study is a valid procedure.

If the outpatient services rates are not adjusted, the outpatient service system faces a potential crisis. Providers in this study were forced to cross-fund $16.7 millions of dollars annually to deliver outpatient services only partially purchased by the State of Washington. While many of the providers receive private pay fees and private donations these resources do not match the cross-funding requirements. Other loss-coping mechanisms are reviewed in the study including financially dangerous actions such as funding operational losses with long-term loans. While most of the current sample (n=31 based on available data) show a weighted average operating margin of 2.3% (net asset increase as a percentage of revenues) for the year under study, over 60% of the outpatient providers are facing financial losses or near-losses from overall operations that include outpatient services. ***Financial failure or near financial failure is a reality for many of these providers.*** Many of the remaining providers face an on-going financial stress. The 2.3% margin rate (increase in net assets or over-recovery of expenses over revenues) for the State of Washington DASA Outpatient Providers is below average. The State of Washington outpatient provider rate of 2.3% is one-half to one-third of what it should be—5% to 7% for healthy not-for-profit human service agencies

An additional measure of financial stress can be observed in the working-capital ratios (current assets divided by current liabilities = working capital ratio) and the ability to meet upcoming debts within the next operating cycle. Currently 38% of 31 providers are facing financial stress in paying their maturing liabilities. Two (6%) are technically insolvent (current ratio is < 1.0) since the current liabilities exceed the current assets and 10 (32%) are financially stressed with ratios between 1.0 and less than 2.0.

The DASA standards for quality of care for outpatient services could become severely compromised as providers use strategies to reduce costs such as:

- Use of more Chemical Dependency Professional Trainees (CDPT) rather than Chemical Dependency Professionals (CDP)
- Larger group activities, which provide less individual attention.

As fewer Chemical Dependency Professionals (CDP) join the workforce because of low wages this loss of capacity encourages providers to offer services to private-pay or insurance customers rather than serving DASA clients. DASA providers have been cost-shifting for many years and providers are now exhausting future costs-shifts to keep the doors open.

The shortfall estimates are for the participating providers used in this study and if the total system were evaluated, the cross-funding shortfall would be several times the yearly $16.7 million estimate cited earlier.

No private sector business would be expected to sell its product or services at a 47% discount below cost with the expectation of survival, but deep discounting is what DASA outpatient service providers are asked to do. Financial failure or near financial failure is a reality for many of these providers when reviewing losses or near-losses from operations and a weakened ability to pay maturing current debts.

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# I. Introduction

**Purpose of the Technical Assistance**

In October 2006, the Association of County Human Services (ACHS), an affiliate organization of the Washington State Association of Counties (WSAC), and the Washington Department of Social and Health Services Division of Alcohol and Substance Abuse requested assistance from James E. Sorensen, Ph.D., CPA to help determine the appropriate reimbursement rate structure for its outpatient treatment services.

The consultant provided onsite TA to the Association of County Human Services (ACHS), the Provider Advisory Committee, the Outpatient Rate Setting Study Steering Committee, and staff of the Washington Division of Alcohol and Substance Abuse on October 9, 2006 and off-site consultation for 21 days. This report summarizes the State's issues, options, and methods for the determination of rates for its outpatient services.

**Consultant's Background**

James E. Sorensen is professor of accountancy in the School of Accountancy in the Daniels College of Business at the University of Denver, a position he has held since 1972. He teaches Not-for-Profit Accounting in the School of Accountancy and serves as the Strategic Cost Management coordinator for the integrated MBA for Daniels where he teaches the use of strategic cost management, the Balanced Scorecard (BSC), ISO-9000: 2000, decision support tools and related computer software.

Sorensen's work is often cited in the cost determinations of human service agencies. His behavioral health research includes cost-finding, cost-outcome and cost-effectiveness of human service programs. Dr. Sorensen's clients include federal, state and local behavioral health agencies and providers in every state in the United States as well as Puerto Rico and Guam.

Sorensen has published more than 100 articles. His research has appeared in the Journal of Behavioral Health Services & Research (formerly The Journal of Mental Health Administration), Administration and Policy in Mental Health, Management Accounting, Strategic Finance, Journal of Accountancy, The Accounting Review, Journal of International Accounting, Administrative Science Quarterly, Decision Sciences, Accounting, Organizations and Society, and six other journals.

# II. Technical Assistance Report

## A. Important Contextual Issues

The Division of Alcohol and Substance Abuse (DASA) established rates for its outpatient services several years ago and these rates have been adjusted periodically to compensate partially for inflation and other factors. There is a widespread allegation that the current DASA reimbursement rates are ***not*** sufficient to provide the quality of services required by DASA program standards. Current concerns over the adequacy of the funding for outpatient services have emerged from the providers of outpatient services, counties and DASA itself. A central question to be addressed in this consultation is an assessment of the current unit of service costs for the multiple outpatient services contracted by DASA.

## B. Description of the Methodology

Under another contract prepared under the Center for Substance Abuse Treatment State System Technical Assistance Project (Contract 270-99-7070) in April, 2006, an Outpatient Rate Study Advisory Committee was formed by DASA to guide the review and assessment of the outpatient reimbursement rates for the Division of Alcohol and Substance Abuse (DASA) service providers. The project was to produce usable rates based on the actual costs of providers that the Division of Alcohol and Substance Abuse can use in future State of Washington budgetary requests and in contracting with service providers.

**Initial visit.** In an initial visit the consultant was able to plan with the Outpatient Rate Study Advisory Committee and a selected group of current outpatient service providers. The interest of and the willingness of providers to share financial and operational information was impressive. In this initial visit, the consultant emphasized the value of the independent auditor's (CPA) report. Generally Accepted Accounting Principles (GAAP) for voluntary health and welfare organizations require a functional cost report as part of the independent auditor's report. Some of the most useful cost information about the costs of outpatient services emerges from the functional cost report since it is tied to the independent auditor's opinion about the fair presentation of the general financial statements. Using the independent auditors' reports for the costing of the outpatient services represented an enormous cost savings over a study that required an independent cost-finding on a site-by-site basis.

During the initial visit, the Advisory Committee as well as participating providers suggested the outpatient rate study would be enhanced if the results could be classified by factors believed to influence the cost structures of providers. These factors included:

- Urban or rural delivery site
- Large or small sized delivery organization
- Geographic location in either the eastern or western part of the State
- Type of population treated: adult or youth.

Other factors such as dual diagnosis (including, for example, clients with both alcohol and mental health issues) or clients with differing ethic backgrounds were suggested. The ability to control for these additional factors would be dependent on the number of participating providers exhibiting those characteristics.

Initially estimates of outpatient provider organizations who might participate in the study were set at about 70. An unknown factor was how many of these providers could supply both an independent auditor's report with functional costs as well as a competent assessment of the services provided. To complete a meaningful analysis using the factors identified above would require 40 to 50 responding organizations with both functional cost reports from the independent audits as well as accompanying TARGET reports (described below).

**Next phase.** A review of the independent auditor's report from the providers of outpatient services would be the next major step forward for DASA in assessing the costs of these services. In addition information on the units of service delivered for the time period that matches the reporting period of the auditor's report is required for the outpatient services as defined by the Division of Alcohol and Substance Abuse. The calendar year 2004 or a fiscal year ending somewhere in 2004 was identified as the most appropriate reporting time period.

**Submission of auditor reports, units of service and level of service.** The independent audit reports of outpatient providers along with defined units of services and the State designated level of service were needed to advance the study of outpatient rates. Armed with the functional costs of the services, the costs of management and general administration and the annual units of service provided by service a cost-finding process was completed to determine the various outpatient rates for five services. The services included

- Assessment
- Case Management
- Group Therapy
- Individual Therapy
- Opiate Substitution Treatment

Urinalysis was included initially as one of the outpatient services, but upon the advice of the Outpatient Rate Study Advisory Committee on June 15, 2006 it was dropped since it is an embedded service and not subject to a separate status like the other five outpatient services.

While the independent audit report functional cost report has the rigor of the auditing process, the units of service might not come from a system with as many internal controls that characterize financial reporting systems. The independent auditor is likely to have done a substantive review of the internal controls that produced the financial statements on which s/he is expressing an opinion. To obtain the most reliable reports on services rendered, providers were asked to supply copies of the TARGET system reports required by DASA in reporting outpatient services provided. The TARGET reports were to be for the same time periods as the functional costs reported in the financial statements.

**Functional costing.** All voluntary health and welfare organizations must report expenses by functional categories (namely, program (or services), management, fundraising). This requirement is contained in the Statement of Financial Accounting Standards 117 Financial Statements of Not-for-Profit Organizations issued by the Financial Accounting Standards Board (FASB) in June 1993[1]. The functional cost statement presents the expenses incurred for each program (or function) in detail by object-of-expenditure (namely, salaries, benefits, rents, and so on.). In this study the functional cost statements provided major program costs for drug and alcohol inpatient and outpatient or mental health, for example. The costs of management were reassigned to each major program based on the relative cost of each program to derive a total cost of each program. (The costs of fundraising were excluded from the costs of any program.)

**Assigning cost to outpatient services**. Joint [service] costs are derived from processing a common set of inputs to multiple [services][2]. The program cost for outpatient services derived from the functional cost report is assigned to individual outpatient services using the relative sales value method. The relative sales value method allocates joint cost to joint services on the basis of relative sales value[3]. In this study, the DASA reimbursement rates for various outpatient services were used as the relative sales value. First, the sales value is multiplied by the number of services units produced. Second, the proportion of the total sales value of each joint service to the total sales value of all services is used to assign costs to the service. Third, the total costs assigned to a service are divided by the total number of units of service to derive the weighted average unit cost of service.

In all cases where the provider was able to provide units of service (through the TARGET system) and the independent audit report identified outpatient costs (as well as management costs), the relative sales value method was used.

**The extended study.** The initial contract referenced above was completed in July 2006, but based on the recommendations of the Outpatient Rate Setting Study Steering Committee the number of participating providers needed to be expanded and the range of services needed to be extended to include Opiate Substitution Treatment (OST) in addition to the four services included (namely, Assessment, Case Management, Group Therapy and Individual Therapy) in the earlier study. The Association of County Human Services (ACHS), an affiliate organization of the Washington State Association of Counties (WSAC) in coordination with the Division of Alcohol and Substance Abuse (DASA) requested Clark County to take the lead in contracting with James E. Sorensen, Ph.D., CPA for the study on behalf of its members.

## C. State of Washington Procedures[4]

[1] Financial Accounting Standards Board*, Statement of Financial Accounting Standards No. 117*, "Financial Statement of Not-for-Profit Organizations" (Norwalk, Conn.: FASB, June 1993).
[2] Blocher, E.J., Chen, K.H., Cokins, G. and Lin, T.W. (2005). Cost Management: A Strategic Emphasis," McGraw-Hill (New York) p. 489.
[3] Blocher, E.J., Chen, K.H., Cokins, G. and Lin, T.W. (2005). Op.Cit. p. 491.
[4] Emilio Vela, DASA, e-mails dated April 5, 2006 and October 3, 2006.

**How are data collected and accumulated?** DASA collects data through a Management Information System (MIS) called TARGET. Each provider program enters information into TARGET that enables DASA to produce a periodic report (M4) containing fund source, contract type, modality, activity types, clients served, sessions, hours served and childcare hours. Another TARGET report (M2) contains funding sources, contract type, modality, total assessments (duplicated and unduplicated, clients admitted (duplicated and unduplicated), clients discharged (duplicated and unduplicated). A final TARGET report (D6) reveals the total number of methadone treatment days by provider. These reports were used in this study for the assessment of the quantitative levels of service generated by an outpatient service provider.

Impact of private-pay units of service. Most publicly funded agencies that provide outpatient treatment services collect minimal amounts in private-pay revenues. Some agencies may report 10% of their patients are private pay and, therefore, do not qualify for public funding, but these clients are often the working poor so these private-pay patients may constitute only 3% of an agency's total outpatient service revenues. For the 35 agencies in this study, only 2.5% of the treated outpatient clients were private clients.

In a phone survey conducted with the participants in the study, all (with the exception of one small provider) reported their private pay units of service in the TARGET system. Confirming evidence from the working papers of the study indicates 97% of the 35 participants reported private pay clients in TARGET. A review of TARGET data from an M4-Contract Performance Summary Report[5] for one fiscal year revealed:

- Of the 35 agencies in the study 2.5% of the total population served received services for outpatient treatment that were paid by private funds.
- Of the 35 agencies in the study 6.7% of the total population served received ***services for OST*** that were paid by private funds.
- Of the 35 agencies in the study 14.4% of the total population served received ***outpatient*** OST services that were paid by private funds.

All OST providers report both public and private client services in TARGET. OST providers charge private pay clients the same low rates for outpatient services as they do public clients. OST providers observed frequently they are required to supplement the cost of OST services with other revenue sources.

While some private pay clients units of service may be unreported, the amounts are deemed immaterial and the use of TARGET data for determining units of services for this study is a valid procedure.

**How are the units of service used in this study?** DASA pays treatment providers a rate for each service a client receives. The TARGET system operated by DASA accumulates the various outpatient services delivered by various providers throughout the State. The units of

[5] Emilio Vela, DASA, e-mail dated November 15, 2006.

service accumulated by the DASA TARGET reporting system are used to calculate unit-of-service costs and the typical deficiency of reimbursement as shown in Table 2.

## D. Reports on and Interpretations of the Results

**Classification of participating providers.** Forty three provider organizations responded to the initial and follow-up call for participation. Of the 43 respondents, 35 were able to meet the dual requirements of an independent auditor's report with functional cost requirements as well as TARGET unit of service reports. The smaller usable respondent numbers place some limits on the ability to cross-classify the rates by the key factors identified earlier. The actual profile classification of participating providers is presented in Table 1. The 35 participants exhibited the following factors:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Urban | *71%* | Larger | *74%* | East | *31%* | Adult | *83%* |
| Rural | *29%* | Smaller | *26%* | West | *69%* | Youth | *17%* |
| Total | *100%* | | *100%* | | *100%* | | *100%* |

In summary, the sample was more heavily weighted toward urban, larger organizations located in the western part of the State and providing adult services. Table 1, however, reveals a rich cross-section of providers in the sample.

**Costs exceed reimbursement rates.** Table 2 summarizes the usable data (n = 35) submitted by invited providers. ***For 97% of the responding providers the actual cost of the services provided exceeded the FY2005 DASA reimbursement rates***. The reimbursement deficiency as a percentage of costs was ***47.0%.*** Stated in other words, across all services providers and all services, providers were receiving reimbursement of 53% of costs (total costs of 100% less the deficiency of 47%) when using DASA reimbursement rates.[6] A graphic presentation of the costs, reimbursement rates and deficiency by outpatient service is presented in Figure 1. Figure 2 displays an aggregate level of total billable dollars under current rates, total costs and total cost deficiency for the 35 participating organizations. The deficiency of $16.679 million is 47% of the total outpatient program costs of $35.514 million ($16,679,185/$35,514,357 = 47%).

Price-level adjustments. Price level adjustments to bring the report to 2005 price levels and to FY 2005 rates for comparison were not performed since the price level adjustments for the State of Washington were minor adjustments to the substantial gap between costs and reimbursement rates. As might be expected, the price-level adjustments only worsen the pre-existing gaps by a percentage point.

Protection of providers. This report tries to protect the providers from revealing data that can be specifically related to the individual providers. The providers were concerned generally

[6] A similar conclusion was reached by an earlier study of outpatient reimbursement rates in Washington counties: Looking Glass Analytics, *Outpatient Reimbursement Rates in Washington State: Results from Three Counties,* Olympia, WA, 2005. Reimbursement as a percent of cost for four of the services evaluated in this study, Looking Glass Analytics reported averages of 65% for assessments, 66% for individual therapy, 67% for group therapy and 62% for case management (page 1).

about being singled out in the analysis so the cost of service reports are as clear as possible, but without identifying any specific provider. As requested by Executives of DASA as well as the Outpatient Rate Study Advisory Committee the names of specific providers were deleted.

Effort to use key factors. The use of key factors to cross-classify the respondents has tremendous appeal, but the number of respondents in some categories limited the presentation of data without potentially revealing the identity of individual agencies. However, a number of comparisons are possible. Table 3 makes an effort by comparing rural and urban adult providers with exclusively youth providers identified as a separate group. While rural adults are higher (49.9%) than urban adults (44.7%) adult providers have a lower cost deficiency than youth providers (61.4%). In Table 2 the deficiency as a percentage of cost is 47% for the overall State average, but variation is noted among adults and youth providers. Rural organizations may be expected to experience higher unit costs because of lower volumes while still needing to provide staffing and administration required of all providers. Rural providers may be able to acquire some resources at lower prices (namely, rental properties), but the lower volumes of services can result in higher per unit of service costs.

Table 4 controls for the size of the organization. Larger adult organizations face a lower deficiency as a percentage of cost (44.7%) when compared to smaller adult organizations (51.1%). Larger organizations while incurring more costs are the beneficiaries of the economic principle of returns to scale. The higher costs are spread over a higher volume, thus the unit cost of service may tend to be lower. Note the exclusively youth providers (61.4%) are separated to enhance the analysis of adult providers.

Table 5 is the most extensive use of the classification factors. The cost deficiency controls for location (eastern or western Washington), size of organization (larger or smaller) and program focus (adult or youth). (The urban or rural status is shown parenthetically within the table.) Eastern Washington providers face the most financial strain with larger adult providers at a 58.2% cost deficiency and smaller adult providers at a 54.3% cost deficiency. Western Washington providers face strains as well with larger adult providers at a 40.5% cost deficiency and smaller adult providers at a 48.6% cost deficiency. (The exclusively youth providers at a 61.4% cost deficiency are presented to account for the entire sample of 35 providers.)

Variation in deficiency percentages. Figure 3 displays the range of the deficiency rates to give the reader a grasp for the empirical variability of these deficiencies. One provider (3% of the sample) is able to earn a modest over-recovery of costs while 34 (or 97%) experience an under-recovery of costs. The most fortunate under-recovery organization is about 2% (-2%) while the most unfortunate is 84% (-84%). The median (average) organization is 48% (-48%).

General and administrative rates. The "general and administrative" allocation to the outpatient service is expressed as a percentage of the **total costs of all services including the general and administrative costs.** Most of the rates of providers are within the 10 to 20 percent range found in many human service programs of the size under review. Ten to twenty percent (with smaller organizations having higher rates and larger organizations having lower rates)

are acceptable values for non-profit human service organizations. "General and administrative" costs that are too low can be as much of a problem as those that are too high since the organization may be under- administered.

**Typical under-funding.** Table 2 examines the reimbursement provided to the responding providers with what it cost the provider to produce the service purchased by the State. Figure 1 gives a clear estimate of the underpayment for all outpatient services and identifies the amount of cross-funding that appears to be happening to support the various outpatient treatment services purchased by the State of Washington. ***Based on the averages, DASA is under-funding its outpatient providers by 43% to 52% of the actual cost of the service (and 47% on the average).*** Serious under-funding for specific services varies from 43.7 % for Group Therapy, 48% for Opiate Substitution Treatment, 49.1% for Assessments, 52.4% for Case Management and to almost 53% (52.6%) for Individual Therapy.

Table 2, especially with an elaboration on the cross-funding, should be of significant value in demonstrating the under-funding crisis faced by many of the outpatient service providers within the State of Washington. In a number of interviews with providers, many mentioned they were not spending as much as they should be to adhere rigorously to program standards (especially regarding personnel) and to replace depreciating long-lived assets. While the study's report reflects the current actual costs, they do not reflect what the costs should be in the eyes of many providers. Additional analysis would be required to ascertain how much additional funding would be required besides the already noted cost reimbursement deficiency.

Effects of under-funding. The effects of under-funding should be revealed in the financial statements of the outpatient providers. While most of the current sample (n=31 because of available data) show a weighted average operating margin for the entire organization of 2.3% (net asset increase as a percentage of revenues) for the year under study, ***over 60% of the outpatient providers are facing financial losses or near-losses from overall operations that include outpatient services. Financial failure or near financial failure is a reality for most of the providers.*** Many of the remaining providers face an on-going financial stress.

The 2.3% margin rate (increase in net assets or over-recovery of expenses over revenues) for the State of Washington DASA Outpatient Providers is ***below average***. In this consultant's experience with behavioral health organizations extending through every State in the United States financially healthy not-for-profit human service agencies show a 5% to 7% margin rate. Not-for-profits ***need to earn*** revenues in excess of costs in order to build working capital (current assets over current liabilities), for example, to

- deal with inflation
- deal with the uncertainty of cash flows from receivables, donations and funding sources
- start new programs before billing and collection can happen
- replace long-lived assets that are more expensive than the depreciation costs in the Statement of Activities

- replace information and other technical systems that have newer and more expensive technology
- cover for changing funding sources that may not stop or start on a timely basis
- fund competitive salary increases before they can be recovered from funding sources.

The State of Washington outpatient provider rate of 2.3% is one-half to one-third of what it should be. In some States, human service systems are permitted to over-recover a 5% to 7% (of revenues over expenses) on a five-year average so the providers are able to cope with the foregoing financial stresses and strains. The five-year average is computed so variations in one year are neither penalized nor ignored. In one state, for example, there is no renegotiation on the rates unless the five year average has been exceeded.

An additional measure of financial stress can be observed in the working-capital ratios (current assets divided by current liabilities = working capital ratio) and the ability to meet upcoming debts within the next operating cycle. ***Currently 38% of 31 providers are facing financial stress in paying their maturing liabilities.*** Two (6%) are technically insolvent (current ratio is < 1.0) since the current liabilities exceed the current assets and 10 (32%) are financially stressed with ratios between 1.0 and less than 2.0. The remaining 19 (61%) exhibit ratios of 2.0 or better and conform to the normative expectation of two dollars of current assets for each dollar of current liabilities. One of the technically insolvent providers has been flagged in its financial statements by the independent auditor on the issue of going-concern—will it be able to operate through the operating cycle?

**Typical provider mechanisms used to cope with operating losses[7].** How do alcohol and drug Outpatient Treatment agencies manage to stay in business when faced by continuous losses or near losses from operations? This question was asked during the October 9, 2006, Outpatient Treatment Cost Rate Study Advisory Committee meeting in Seattle, WA. The answer came in many forms from providers around the table. Many providers stated that they simply do whatever it takes to stay in business and these actions can work against them eventually. Some of the ways that outpatient agencies, providing services with public funds, keep their doors open for services were as follows:

- Require private-pay fees or collect fees from the client's (third-party) insurance.
- Use restricted and unrestricted grants or gifts.
- Utilize funds from other revenue sources to cross-funding services.
- Delay payment of accounts payable **or** overuse of credit lines.
- Acquire loans based on long-lived assets or future revenue and/or defer payments on existing debt.
- Reduce staff benefits and salaries.
- Increase the percentage of treatment staff time spent in direct service.
- Reduce treatment personnel (and increase case loads for others).
- Do not replace staff when they leave and/or replace by hiring trainees.

[7] This section is drawn from notes prepared by Emilio Vela, Division of Alcohol and Substance Abuse, recorded at the October 9, 2006, Outpatient Treatment Cost Rate Study Advisory Committee meeting in Seattle, WA.

- Reduce administration.
- Defer maintenance on or replacement of facilities.
- Close satellite or branch offices.
- Merge with other providers to reduce costs.
- Build shared facility with long-term leases.

Many of the financial effects of these fiscal actions by agencies provide only temporary relief. In the short term these agencies end up increasing cash and reducing costs, but this can end up creating financial doom for an outpatient provider. Table 6 summarizes the coping techniques along with the potential short- or long-term effects.

As fewer Chemical Dependency Professionals join the workforce because of low wages this loss of capacity encourages providers to offer services to private-pay or insurance customers rather than serving DASA clients. DASA providers have been cost-shifting for many years and providers are now exhausting future costs-shifts to keep the doors open**.**

## E. Recommendations and Impact

If the outpatient services rates are not adjusted, the outpatient service system faces a potential crisis. Providers (as shown in Figure 2) in this study were forced to cross-fund $16.7 millions of dollars to deliver outpatient services only partially purchased by the State of Washington. While most of the providers charge private-pay clients and receive private donations these resources do not match the cross-funding requirements. Other loss-coping mechanisms are reviewed in Table 6. The shortfall estimates are for the participating providers used in this study and if the total system were evaluated, the cross-funding shortfall would be several times the $16.7 million estimate cited earlier. **As a summary observation for all of the DASA outpatient services, the State of Washington is short-changing its outpatient providers.**

## F. Outcomes

If DASA is able to convince the State of Washington Legislature of the dire funding situation for the outpatient service system, then this project and DASA efforts will be successful. If not, the outpatient provider system may implode partially with a catastrophic impact for the citizens of the State of Washington. ***Over 60%*** of the outpatient providers (n=31) are facing financial losses or near-losses from overall operations that include outpatient services. ***Financial failure or near financial failure is a reality for many of these providers.*** Many of the remaining providers face an on-going financial stress. Currently 38% of 31 providers are facing financial stress in paying their maturing liabilities.

The well-articulated DASA standards for quality of care for outpatient services may have limited impact since many of the current providers will not be able to provide any services at any level. No private sector business would be expected to sell its product or services at a 47% discount below cost (Table 2) with the expectation of survival, but deep discounting is what DASA outpatient service providers are asked to do.

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# Appendix: Tables and Figures

**Table 1**
**Outpatient Services Rate Study**
**Division of Alcohol and Substance Abuse**
**State of Washington**
**Profile Classification of Participating Providers**

| Classification: | | | | |
|---|---|---|---|---|
| Location: | Size: | Direction: | Population: | Number |
| Urban/Rural | Large/Small | East/West | Adult/Youth | in Group |
| *Adult:* | | | | |
| R | L | E | A | 3 |
| R | S | E | A | 4 |
| R | S | W | A | 2 |
| | | | | 9 |
| U | L | E | A | 4 |
| U | L | W | A | 14 |
| U | S | W | A | 2 |
| | | | | 20 |
| *Youth:* | | | | |
| U | L | W | Y | 5 |
| R | S | W | Y | 1 |
| | | | | 6 |
| Total: | | | | 35 |

**Table 2**
**Outpatient Services Rate Study**
**Division of Alcohol and Substance Abuse**
**State of Washington**
**Calculation of Weighted Average Unit Cost Deficiency**

| Variable | Service: | | | | | |
|---|---|---|---|---|---|---|
| | Assess | Case Mgt | Group | Individual | OST | Total |
| *# of Providers* | *34* | *29* | *34* | *34* | *5* | *35* |
| **Weighted average unit cost** | $ 179.34 | $ 63.01 | $ 31.75 | $ 119.95 | $ 19.92 | $ 33.43 |
| **DASA Reimbursement rate** | $ 91.22 | $ 30.00 | $ 17.88 | $ 56.84 | $ 10.36 | $ 17.73 |
| **Deficiency** | $ (88.12) | $ (33.01) | $ (13.87) | $ (63.11) | $ (9.56) | $ (15.70) |
| **Deficiency as a % of Cost** | -49.1% | -52.4% | -43.7% | -52.6% | -48.0% | **-47.0%** |

Source: Oct2006Run7ATemplate2(version1)

**Table 3**
**Outpatient Services Rate Study**
**Division of Alcohol and Substance Abuse**
**State of Washington**
**Calculation of Weighted Average Unit Cost Deficiency by Adult (Rural vs. Urban) and Youth**

| Variable | Service: | | | | | |
|---|---|---|---|---|---|---|
| | Assess | Case Mgt | Group | Individual | OST | Total |
| ***# of Providers: rural adult*** | *8* | *7* | *9* | *9* | *1* | *9* |
| Weighted average unit cost: | $ 191.86 | $ 51.99 | $ 35.54 | $ 116.83 | $ 18.69 | $ 43.01 |
| DASA Reimbursement rate: | $ 91.22 | $ 30.00 | $ 17.88 | $ 56.84 | $ 10.36 | $ 21.54 |
| Deficiency | $ (100.64) | $ (21.99) | $ (17.66) | $ (59.99) | $ (8.33) | $ (21.46) |
| Deficiency as a % of Cost | -52.5% | -42.3% | -49.7% | -51.3% | -44.6% | **-49.9%** |
| ***# of Providers: urban adult*** | *20* | *18* | *20* | *19* | *4* | *20* |
| Weighted average unit cost: | $ 164.87 | $ 59.63 | $ 30.08 | $ 111.21 | $ 19.96 | $ 30.18 |
| DASA Reimbursement rate: | $ 91.22 | $ 30.00 | $ 17.88 | $ 56.84 | $ 10.36 | $ 16.69 |
| Deficiency | $ (73.65) | $ (29.63) | $ (12.20) | $ (54.37) | $ (9.60) | $ (13.48) |
| Deficiency as a % of Cost | -44.7% | -49.7% | -40.6% | -48.9% | -48.1% | **-44.7%** |
| ***# of Providers: youth*** | *6* | *4* | *5* | *6* | *0* | *6* |
| Weighted average unit cost: | $ 273.38 | $ 97.14 | $ 40.69 | $ 161.11 | --- | $ 71.52 |
| DASA Reimbursement rate: | $ 91.22 | $ 30.00 | $ 17.88 | $ 56.84 | $ 10.36 | $ 27.59 |
| Deficiency | $ (182.16) | $ (67.14) | $ (22.81) | $ (104.27) | --- | $ (43.94) |
| Deficiency as a % of Cost | -66.6% | -69.1% | -56.1% | -64.7% | --- | **-61.4%** |

Source: Oct 2006Run8Template2(version1)

**Table 4**
**Outpatient Services Rate Study**
**Division of Alcohol and Substance Abuse**
**State of Washington**
**Calculation of Weighted Average Unit Cost Deficiency by Adult (Large & Small) and Youth**

| Variable | Service: | | | | | |
|---|---|---|---|---|---|---|
| | Assess | Case Mgt | Group | Individual | OST | Total |
| ***# of Providers: larger adult*** | *21* | *17* | *21* | *20* | *5* | *21* |
| Weighted average unit cost: | $ 163.21 | $ 58.94 | $ 30.45 | $ 109.05 | $ 19.92 | $ 30.18 |
| DASA Reimbursement rate: | $ 91.22 | $ 30.00 | $ 17.88 | $ 56.84 | $ 10.36 | $ 16.68 |
| Deficiency | $ (71.99) | $ (28.94) | $ (12.57) | $ (52.21) | $ (9.56) | $ (13.50) |
| Deficiency as a % of Cost | -44.1% | -49.1% | -41.3% | -47.9% | -48.0% | **-44.7%** |
| ***# of Providers: smaller adult*** | *7* | *8* | *8* | *8* | *0* | *8* |
| Weighted average unit cost: | $ 194.97 | $ 57.54 | $ 35.06 | $ 129.60 | --- | $ 48.54 |
| DASA Reimbursement rate: | $ 91.22 | $ 30.00 | $ 17.88 | $ 56.84 | $ 10.36 | $ 23.74 |
| Deficiency | $ (103.75) | $ (27.54) | $ (17.18) | $ (72.76) | --- | $ (24.80) |
| Deficiency as a % of Cost | -53.2% | -47.9% | -49.0% | -56.1% | --- | **-51.1%** |
| ***# of Providers: youth*** | *6* | *4* | *5* | *6* | *0* | *6* |
| Weighted average unit cost: | $ 273.38 | $ 97.14 | $ 40.69 | $ 161.11 | --- | $ 71.52 |
| DASA Reimbursement rate: | $ 91.22 | $ 30.00 | $ 17.88 | $ 56.84 | $ 10.36 | $ 27.59 |
| Deficiency | $ (182.16) | $ (67.14) | $ (22.81) | $ (104.27) | --- | $ (43.94) |
| Deficiency as a % of Cost | -66.6% | -69.1% | -56.1% | -64.7% | --- | **-61.4%** |

Source: Oct 2006Run9Template2(version1)

**Table 5**
**Outpatient Services Rate Study**
**Division of Alcohol and Substance Abuse**
**State of Washington**
**Calculation of Weighted Average Unit Cost Deficiency by Adult (Large & Small & East and West) and Youth**

| Variable | Service: | | | | | |
|---|---|---|---|---|---|---|
| Total | Assess | Case Mgt | Group | Individual | OST | Total |
| *# of Providers: eastern larger adult* | *7* | *3* | *7* | *6* | *1* | *7* |
| *(3 rural; 4 urban)* | | | | | | |
| Weighted average unit cost: | $ 236.79 | $ 44.36 | $ 43.50 | $ 140.52 | $ 18.69 | $ 50.22 |
| DASA Reimbursement rate: | $ 91.22 | $ 30.00 | $ 17.88 | $ 56.84 | $ 10.36 | $ 20.97 |
| Deficiency | $ (145.57) | $ (14.36) | $ (25.62) | $ (83.68) | $ (8.33) | $ (29.25) |
| Deficiency as a % of Cost | -61.5% | -32.4% | -58.9% | -59.5% | -44.6% | **-58.2%** |
| *# of Providers: western larger adult* | *14* | *14* | *14* | *14* | *4* | *14* |
| *(14 urban)* | | | | | | |
| Weighted average unit cost: | $ 144.68 | $ 61.73 | $ 26.21 | $ 98.12 | $ 19.96 | $ 26.83 |
| DASA Reimbursement rate: | $ 91.22 | $ 30.00 | $ 17.88 | $ 56.84 | $ 10.36 | $ 15.97 |
| Deficiency | $ (53.46) | $ (31.73) | $ (8.33) | $ (41.28) | $ (9.60) | $ (10.86) |
| Deficiency as a % of Cost | -36.9% | -51.4% | -31.8% | -42.1% | -48.1% | **-40.5%** |
| *# of Providers: eastern smaller adult* | *3* | *4* | *4* | *4* | *0* | *4* |
| *(4 rural)* | | | | | | |
| Weighted average unit cost: | $ 212.25 | $ 51.42 | $ 37.14 | $ 151.24 | --- | $ 50.57 |
| DASA Reimbursement rate: | $ 91.22 | $ 30.00 | $ 17.88 | $ 56.84 | $ 10.36 | $ 23.12 |
| Deficiency | $ (121.03) | $ (21.42) | $ (19.26) | $ (94.40) | --- | $ (27.45) |
| Deficiency as a % of Cost | -57.0% | -41.7% | -51.9% | -62.4% | --- | **-54.3%** |
| *# of Providers: western smaller adult* | *4* | *4* | *4* | *4* | *0* | *4* |
| *(2 rural; 2 urban)* | | | | | | |
| Weighted average unit cost: | $ 182.53 | $ 66.77 | $ 33.48 | $ 118.80 | --- | $ 47.04 |
| DASA Reimbursement rate: | $ 91.22 | $ 30.00 | $ 17.88 | $ 56.84 | $ 10.36 | $ 24.20 |
| Deficiency | $ (91.31) | $ (36.77) | $ (15.60) | $ (61.96) | --- | $ (22.84) |
| Deficiency as a % of Cost | -50.0% | -55.1% | -46.6% | -52.2% | --- | **-48.6%** |
| *# of Providers: youth* | *6* | *4* | *5* | *6* | *0* | *6* |
| *(1 rural; 5 urban)* | | | | | | |
| Weighted average unit cost: | $ 273.38 | $ 97.14 | $ 40.69 | $ 161.11 | --- | $ 71.52 |
| DASA Reimbursement rate: | $ 91.22 | $ 30.00 | $ 17.88 | $ 56.84 | $ 10.36 | $ 27.59 |
| Deficiency | $ (182.16) | $ (67.14) | $ (22.81) | $ (104.27) | --- | $ (43.94) |
| Deficiency as a % of Cost | -66.6% | -69.1% | -56.1% | -64.7% | --- | **-61.4%** |

Source: Oct 2006Run10Template2(version1)

Table 6
Coping Mechanisms to Offset Operating Losses by DASA Providers

| # | ***Description of Approach*** | ***Financial Effect*** | ***Potential Operational Effect*** |
|---|---|---|---|
| | | | |
| 1. | Require private-pay fees or collect fees from the client's (third-party) insurance | Increase total cash and revenues | Off-set DASA type expenses to the extent private-pay fees or insurance payments are available; usually this source is a small percentage of total revenues because the typical private-pay client is in the working-poor and, therefore, makes only modest payments |
| 2 | Use non-restricted grants or gifts | Increase total cash and revenues | Off-set DASA type expenses so long as grant or gift is available |
| 3. | Use restricted grants or gifts | Increase total cash and revenues | Off-set DASA type expenses so long as grant or gift is available |
| 4. | Cost-offset using other programs where Revenues exceed Expenses | Use cash from one program to cover expenses from another | Off-set DASA costs so long as other programs have over-recovery; may meet objections from other funding sources |
| 5. | Delay paying accounts payable | Slow-down the effect of liabilities on cash flow | Short-term cash conservation effects—eventually current liabilities have to be paid to remain in operation |
| 6. | Use short-term loans (or lines of credit) | Increase cash and current Liabilities | Using equity to finance operating costs—future of payoff of liability is an open question |
| 7. | Use long-term loans | Increase cash and non-current liabilities | Using equity to finance operating costs—future of payoff of liability is an open question and if not paid may lead to bankruptcy (and no DASA services) |
| 8. | Implement across-the-board cost cuts | Reduce expenses and cash outflows | Cutting salary or benefits by x % reduces future expenses but may decrease morale and increase staff turnover |
| 9. | Increase the % of treatment staff time spent in direct service | Hold personnel expense constant while increasing billable units of service to increase revenue and cash | Maintains current level of billable revenues, but increasing % of time in direct service beyond healthy professional limits (while increasing units of production ) can lead to poorer morale, higher staff turnover and lower quality of care |
| 10. | Reduce treatment personnel | Reduce expenses and conserve cash | Treatment capacity is affected downward resulting in higher caseloads for remaining personnel, potential dilution of quality of care and uncertain effects on unit cost of service |
| 11. | Replace personnel turnover with less experienced or lower qualified personnel , for example, use of more CDPTs rather than CDPs | Reduce expenses and conserve cash | May lead to lower cost per unit of service, but quality of care may be lowered as well; length of stay of clients may be increased and larger group sizes may result |
| 12. | Reduce administration | Reduce expenses and conserve cash | May lower administration as a % of total expenses, but if a critical mass is not maintained overall administrative capability may be diminished |
| 13. | Defer maintenance or asset replacement | Reduce expenses and/or capital outlays and conserve cash | Resources recovered to repair and replace long-lived assets are insufficient and/or may be consumed in operations; ability to replace long-lived assets is impaired |
| 14. | Close satellite operations | Reduce expenses and conserve cash | Out-of-pocket expenses maybe reduced (e.g., travel, rent) but accessibility may be reduced |
| 15. | Provider merges with another provider (or agency) | Reduce expenses and conserve cash | Elimination of duplicate administrative or clinical effort is expected to reduce overall costs of operation; unit cost of service is expected to decrease |
| 16. | Build shared facility with long-term leases (funded by providers, County and State) | Reduce infrastructure (long-lived asset) expenses and cash flows | May lower cash demands for future operations, but fair-market value of donated facilities will still appear in cost per unit computations |

**Figure 1**
**Outpatient Services Rate Study**
**Division of Alcohol and Substance Abuse**
**State of Washington**
**Calculation of Weighted Average Unit Cost Deficiency**

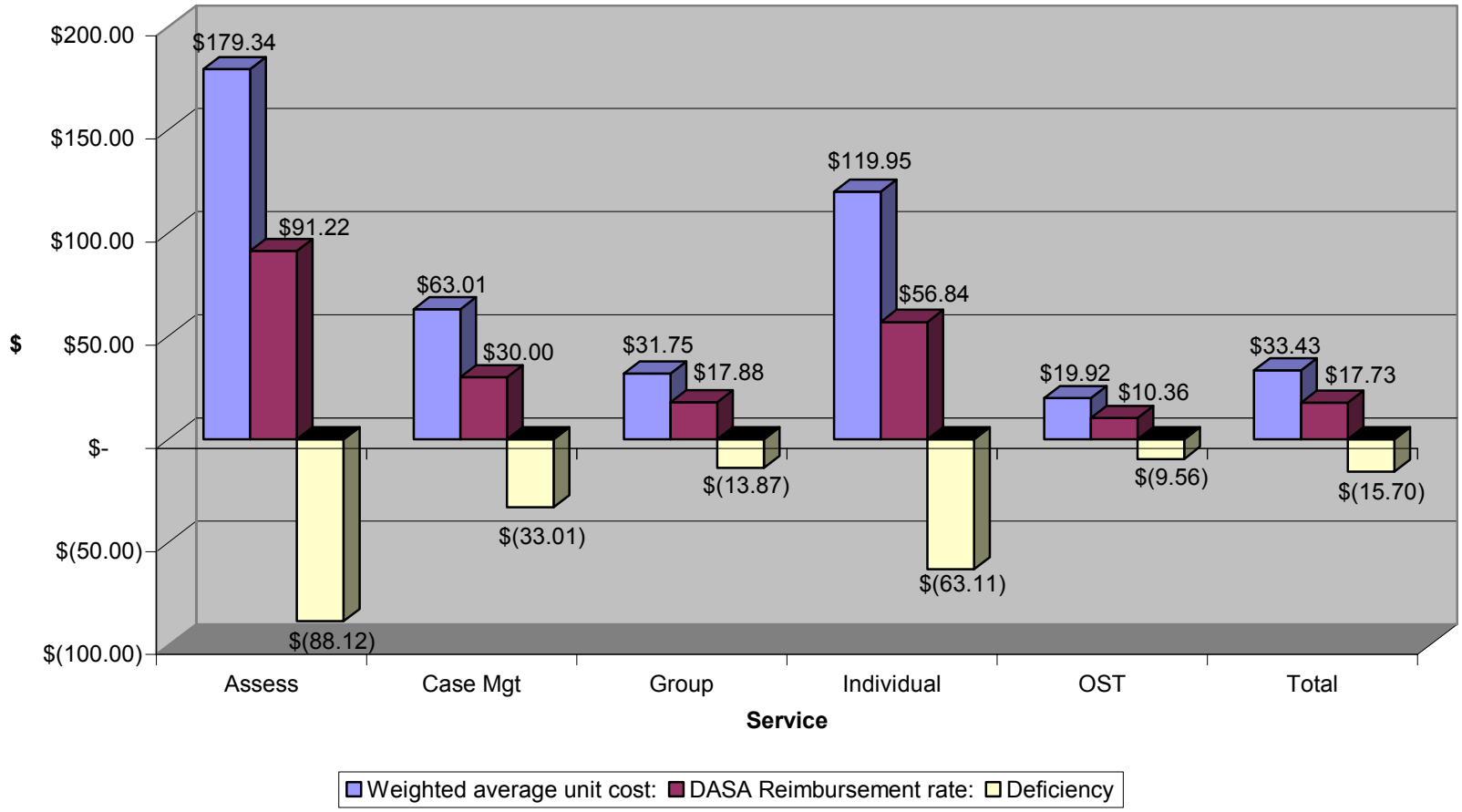
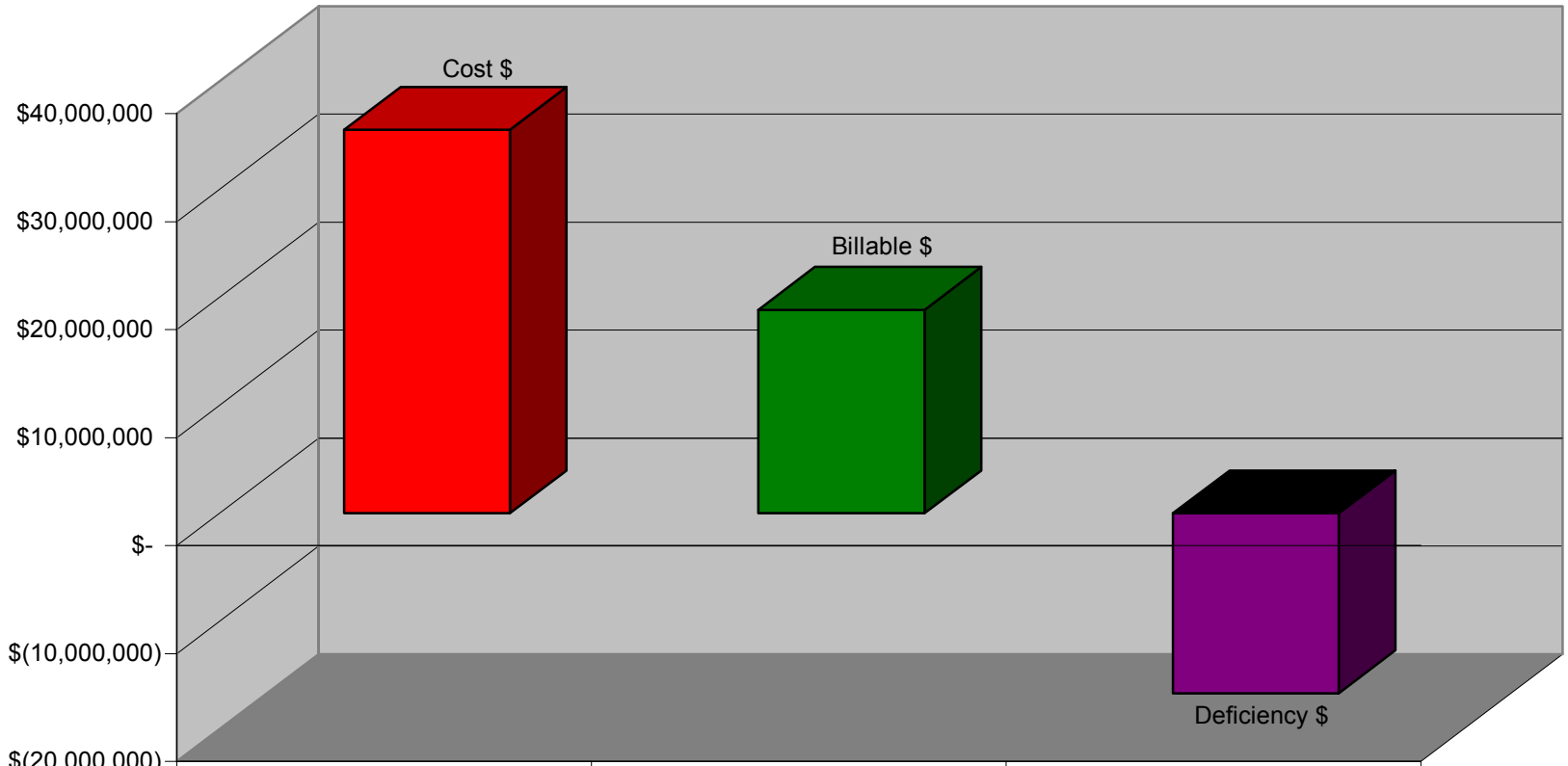
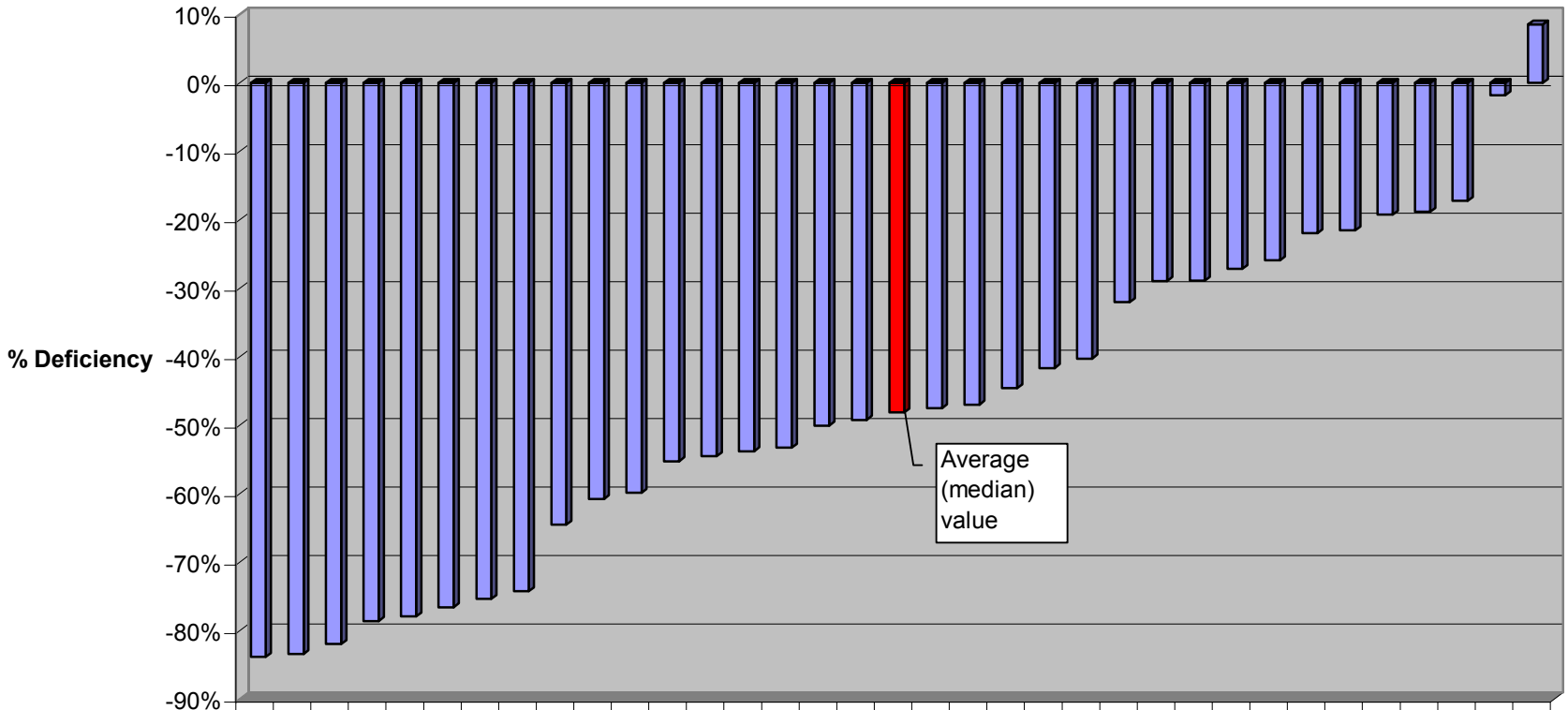


**Figure 2**
**Outpatient Service Rate Study**
**Division of Alcohol and Substance Abuse**
**State of Washington (n=35)**
**Total Billable Dollars, Total Costs and Total Deficiency Cost Dollars**




| | Cost $ | Billable $ | Deficiency $ |
|---|---|---|---|
| Series1 | $35,514,357 | $18,835,171 | $(16,679,185) |

**Figure 3**
**Outpatient Services Rate Study**
**Division of Alcohol and Substance Abuse**
**State of Washington**
**Deficiency as a % of Cost by Provider (n=35)**




| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deficiency Cost % | -84 | -83 | -82 | -79 | -78 | -77 | -75 | -74 | -65 | -61 | -60 | -55 | -55 | -54 | -53 | -50 | -49 | -48 | -47 | -47 | -45 | -42 | -40 | -32 | -29 | -29 | -27 | -26 | -22 | -22 | -19 | -19 | -17 | -2% | 9% |